Evidence-Based Leadership Council (EBLC)
Comments on Senate Finance Chronic Care Policy Options Paper

The Evidence-Based Leadership Council (EBLC) appreciates this opportunity to provide comments on the Bipartisan Chronic Care Working Group Policy Options Document. We applaud the thoughtful, deliberate, bipartisan process and agree that effectively addressing the problems identified should be a high priority for Congress.

EBLC has noteworthy expertise on chronic care issues and works in close collaboration with hundreds of community-based organizations that provide services to millions of older Americans on a daily basis. The EBLC is a national collaborative of evidence-based program developers and community organization representative working to increase delivery of evidence-based programs to measurably improve the health and well-being of diverse older adults with multiple chronic conditions. We provide technical assistance to successfully implement and sustain programs with proven outcomes, including better self-management and, as a result, improved health outcomes. Nationally recognized leaders in older adult health and wellness comprise the EBLC, with program developers from self- and medication-management (Stanford CDSMP suite of programs, EnhanceWellness, and HomeMeds), physical activity (EnhanceFitness, Healthy Moves and Fit! & Strong), falls (Matter of Balance), and depression management (PEARLS and Healthy IDEAS) programs. Community based organization executives from Partners in Care Foundation, CA, The Health Trust, CA, Florida Health Network, Area Agency on Aging Tarrant County, TX, Fairhill Partners, OH, and Elder Services of the Merrimack Valley, MASS also sit on the EBLC.

Our comments are focused on two areas: two policy recommendations that are not currently included in the options paper (a demonstration program on Chronic Disease Self-Management Education, and improving the annual Medicare Wellness Visit), and our support for and views on several proposals that are included.

Although there are a variety of thoughtful options in the paper that have some potential to improve Medicare chronic care, we are disappointed that, in general, the options fail to adequately address three significant concerns and opportunities that merit additional consideration and analysis:

- The fact that healthy behaviors improve health and reduce spending. Unfortunately, this is not a prevailing paradigm in the Medicare program. Medicare has failed to keep people healthy and slow the rate of adding new chronic conditions and complications. There is strong evidence that patients with chronic illnesses have better outcomes and lower costs when behavior changes are implemented;
- The need for patients to be in charge of their health care and given the tools to make informed decisions based on their values and goals. Despite recent platitudes on "patient-centered care", there has been little focus by Medicare and health plans on the central role individuals play in proactively managing their health conditions. Providers and plans must implement and be held accountable for evidence-based patient engagement strategies and measured and rewarded based their success in meeting needs identified by patients and family caregivers; and
- The ability of community-based aging services organizations, including the public health community, to address critical non-medical needs that drive Medicare costs and affect health outcomes. There is an unfortunate bias in Medicare that only medical care providers and the medical care industry can improve beneficiaries' health. To date, Congress and CMS have not sent needed signals that they expect and will pay for community-based interventions that have been shown to improve health, self-efficacy and patient engagement.

We support and are pleased that some of these considerations are recognized under the option on developing quality measures, but believe much more can and must be done.

Our concerns are reflected in the Wagner Chronic Care Model (CCM), developed in the mid-1990s and refined in 1997, which is a widely accepted conceptual model for treatment and management of chronic disease and identifies the essential elements of a high quality health care system. These elements include not only the organization and delivery design of the health system itself, but also components that involve the community and self-management support. A key feature of the CCM is its explicit attention to the need to empower and prepare patients to improve health outcomes through the use of community resources and self-management support, existing outside of the clinical setting both in-person and online. Under the model, effective chronic care systems emphasize the patient's central role in managing their health, as well as using effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving, and follow-up. Disease control and outcomes depend to a significant degree on the effectiveness of self-management. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness.

Another key element of the model is mobilizing community resources to better meet patient needs, stating that "Community programs can support or expand a health system's care for chronically ill patients, but systems often don't make the most of such resources." Effective chronic care systems need to "form partnerships with community organizations to support and develop interventions that fill gaps in needed services."

The options paper also does not adequately account for and address a number of the important goals outlined in the December 2010 Department of Health and Human Services report: Multiple Chronic Conditions: A Strategic Framework: Optimum Health and Quality of Life.[1] For example, goal 2 of the framework is to "Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions." Specific strategies from the framework in this area include:

- Strategy 2.A.1. Continually improve and bring to scale evidence-based, self-care management activities and programs, and develop systems to promote models that address common risk factors and challenges that are associated with many chronic conditions.
- Strategy 2.A.2. Enhance sustainability of evidence-based, self-management activities and programs.
- Strategy 2.A.3. Improve the efficiency, quality, and cost-effectiveness of evidence-based, self-care management activities and programs.

We strongly encourage further consideration of additional options that will incorporate these strategies. In our view, this can best be accomplished by improving access to the Stanford Chronic Disease Self-Management Program (CDSMP), one of the most well-known and researched evidence-based programs. Providing incentives under Medicare to make CDSMP and similar evidence-based programs available to targeted beneficiaries who need them is the best starting point for moving forward in achieving the Framework goals above.

A number of research studies have demonstrated positive changes from CDSMP in self-efficacy, health behaviors, physical and psychological health status, symptom management, and health care utilization. For example, a 2013 national study supported by the Administration on Aging of 1,170 CDSMP enrollees found annual $364 per capita savings in reduced emergency room visits and hospital utilization, with potential savings of $6.6 billion if 10% of those with one or more chronic conditions participated in the

[1] http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf

program.[2] For a summary of national and state translational research studies that demonstrate how CDSMP has helped to achieve better health, better care, and lower costs, go to http://www.EBLC.org/improve-health/center-for-healthy-aging/content-library/Health-Outcomes-Evaluation-FINAL-DRAFT-022515.pdf. Several studies have also found long-term benefits beyond 12 months.[3]

In addition to community-based programs, there is an effective on-line version of CDSMP which would allow use of technology to spread self-management strategies with broader reach so that they are accessible to those not able to or interested in participating in group based, in-person programs.[4]

Currently, the Prevention and Public Health Fund has provided only $8 million in discretionary funds per year for these programs, now available on a limited basis in only 8 states. The fact is, for these programs to be sustainable and available to those who need them, and for significant savings to be realized, Medicare and Medicaid will need to play a greater role.

Despite the long history and strong evidence behind CDSMP, there is only limited but growing penetration among MA plans. Currently, CDSMP is available in Kaiser Permanente, Group Health Cooperative, Commonwealth Care Alliance, Senior Whole Health and the Tufts Health Plan. Some of the current barriers to growth include:

- There are no billing codes available to receive reimbursement for these programs.
- There are insufficient incentives to offer evidence-based health and behavior change programs that extend beyond clinic walls. Similarly, there are limited incentives for insurers to increase their enrollees' activation or provide formal education for their members that have chronic disease.
- MA plans want to offer similar benefits across their entire population and across state lines, but capacity does not yet exist in all communities. Although CDSMP has been scaling up, it has only reached critical mass in a small but increasing number of states.
- Most MA plans are still not prepared to embrace the value of community based services, in part because their administrative and medical leadership are not familiar with these programs. They often do not react positively to programs outside the medical care system until it is a regulatory imperative.
- MA plans are still in an early stage of assuming responsibility for behavior change and population health management.
- Plans often focus more on short-term, as opposed to longer term, cost savings. As is the case for a number of new initiatives with start-up and training expenses, costs may temporarily increase by a modest amount, but over the long term, savings will be realized through reduced ER use, hospitalizations and readmissions.

Another area not addressed in the options paper that has significant potential to improve outcomes and reduce Medicare spending improving access to evidence-based falls prevention programs. Falls are frequent, expensive, and largely avoidable. One in three Americans aged 65 and over falls each year.[5] In 2013, 2.5 million nonfatal fall injuries among older adults were treated in emergency rooms with more

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[2] http://www.EBLC.org/assets/files/pdf/center-for-healthy-aging/National-Study-Brief-FINAL.pdf

[3] See Lorig, et al, Online Diabetes Self-Management Program: A Randomized Study, Diabetes Care, Volume 33, Number 6 (2010);
Lorig, et al, Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes, Medical Care, Volume 39, Number 11 (2001, pp. 1217–1223); and
Lorig, et al, Evidence Suggesting That Health Education for Self-Management in Patients with Chronic Arthritis has Sustaining Health Benefits While Reducing Health Care Costs, Arthritis and Rheumatism, Vol. 36, No. 4 (April 1993).
Copies available upon request

[4] For example, see Online Diabetes Self-Management: A Randomized Study at http://www.ncbi.nlm.nih.gov/pubmed/20299481

[5] Tromp AM, Pluijm SMF, Smit JH, et al. Fall-risk screening test: a prospective study on predictors for falls in community-dwelling elderly. J Clin Epidemiol 2001;54(8):837–844.

than 734,000 of these hospitalized.[6] In 2013, $34 billion in direct medical costs was spent treating older adults for the effects of falls, with 78% of these costs reimbursed by Medicare.[7] Medicare costs per fall averaged $14,306 and $21,270.[8] If we cannot stem the rate of increase in falls, it is projected that the cost in 2020 will be $67.7 billion, including Medicare costs estimated at about $48 billion.[9]

A number of evidence-based programs are now available which have been shown to reduce falls and save money. When compared with controls, the Tai Ji Quan: Moving for Better Balance intervention reduced falls by 55%;[10] the Stepping On program reduced falls by 30%;[11] and the Otago Exercise Program reduced falls by 35% when delivered to adults 80 years of age and older.[12] A *Journal of Safety Research* special report from the CDC titled: "A cost-benefit analysis of three older adult fall prevention interventions"[13] found that:

- Tai Ji Quan: Moving for Better Balance had an average cost per participant of $104.02, an average expected benefit of $633.90, and an ROI of 509% for each dollar invested.
- The Otago Exercise Program had an average cost per participant of $339.15, an average expected benefit of $768.33 for participants over age 80, and a return-on-investment (ROI) of 127% for each dollar invested for this group.
- Stepping On had an average cost per participant of $211.38, an average expected benefit of $345.75, and an ROI of 64% for each dollar invested.

In addition, the November 2013 Centers for Medicare and Medicaid Services (CMS) Evaluation of Community-based Wellness and Prevention Programs analysis found that participation in the A Matter of Balance (MOB) falls prevention program was associated with a $938 decrease in total medical costs per year. This finding was driven by a $517 per participant reduction in unplanned hospitalization costs, a $234 reduction in skilled nursing facility costs, and an $81 reduction in home health costs.[14]

While the concerns above merit additional discussion and exploration among leading experts in these areas, below are EBLC's specific comments and recommendations on the options paper.

1. Conduct a Demonstration Project on Integrated Self-Care Planning (ISP)

Effective management of chronic conditions requires more than health care—it takes people and caregivers who consistently perform small actions, such as taking medications on time, checking blood pressure or glucose, eating well, and being physically active. Often older adults with multiple chronic

[6] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online].
[7] Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and nonfatal falls among older adults. Injury Prevention 2006a;12:290–5
[8] Shumway-Cook A, Ciol MA, Hoffman J, Dudgeon BJ, Yorston K, Chan L. Falls in the Medicare population: incidence, associated factors, and impact on health care. Physical Therapy 2009.89(4):1-9.
[9] Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. Journal of Forensic Science 1996;41(5):733–46.
[10] Li F, Harmer P, Fisher KJ, McAuley E, Chaumeton N, Eckstrom E, Wilson NL. Tai Chi and fall reductions in older adults: A randomized controlled trial. Journal of Gerontology. 2005 Feb;60A(2):187–94.
[11] Clemson L, Cumming RG, Kendig H, Swann M, Heard R, Taylor K. The effectiveness of a community-based program for reducing the incidence of falls in the elderly: A randomized trial. Journal of the American Geriatrics Society. 2004 Sep;52(9):1487–94.
[12] Campbell AJ, Robertson MC, Gardner MM, Norton RN, Buchner DM. Falls prevention over 2 years: A randomized controlled trial in women 80 years and older. Age and Ageing. 1999 Oct;28(6):513–8.
[13] Carande-Kulis , VG, Stevens, JA, Beattie, BL & Arias, LA. Cost-benefit analysis of three older adult fall prevention interventions; Journal of Safety Research, 2015.
[14] Report to Congress in November 2013: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act.

conditions need services from the aging network. However, self-management education and support in health systems and the community are highly fragmented, and neither sector has a practical process for integrating services at the patient/consumer level.

To fill this gap, a demonstration program should be developed and implemented to test Integrated Self-Care Planning (ISP), in which primary care and community service providers collaborate and integrate support to help older adults and their caregivers reach personal goals for aging well. This new process would bring together older adults, caregivers, primary care providers, aging network providers, and public health organizations to develop and implement a shared pathway for managing each person's chronic conditions. The approach would span medical, community-based, and individual efforts to keep medical conditions in check and improve health and quality of life. Practical protocols for team-based care planning would be developed that center on older adults' goals and results within individualized service integration.

The ISM initiative would have two overarching goals:

- Improve health and quality of life outcomes for older people who have multiple chronic conditions (i.e., the target population).
- Reduce preventable hospitalizations and emergency room visits for this population in order to lower per capita health care expenses for the target population.

Using the ISP process, a primary care provider and trained community coordinator from an aging network provider would help older adults and caregivers set and track personal goals and outcomes. Support and coaching would be provided to help overcome barriers to achieving the goals. This care team would draw on health system and community resources to guide the coordinated delivery of self-care education, programs and services from both sources. The ISP model would directly respond to the call from health systems, payers, and consumer advocates for integrating clinical and community-based support for self-care.

It is essential to apply clear criteria to determine which patients will likely benefit from new services/ interventions. Patient identification and monitoring are also critical to assure the criteria are being applied. The Secretary should be given discretion to determine the target population for receiving services under the demonstration. Factors to consider include the HCC (Hierarchical Condition Categories – mentioned on page 6 of the options paper) model, currently used to adjust capitation payments to private health care plans for the health expenditure risk of their enrollees, and targeting patients with low activation or health confidence.

2. Strengthen the Annual Medicare Wellness Visit to Better Promote Healthy Aging

EBLC recommends that this provision be strengthened to better address the needs of older adults with multiple chronic conditions, specifically:

- Improve requirements for screenings and referrals to CDSME and falls prevention interventions, including specific protocols, recommended best processes and practices, and use of CDC's Stopping Elderly Accidents, Deaths, and Injuries (STEADI) tool;
- Develop standards for post-visit follow-up to better ensure compliance with the personalized prevention plan and referrals;
- Broaden the permissible circumstances under which visits can be conducted in a beneficiary's home.

Evidence-based programs (EBPs) should be more fully integrated into the personal action plans developed as a result of the wellness visits. Plans should focus more on self-management needs and

improving patient activation and confidence. Follow up and referrals to evidence-based prevention and wellness programs will maximize the opportunity presented during the visit to engage older adults in carefully planned next steps to improve their health. Plans should include not only is a risk assessment in the required areas, but follow-up action plans for issues such as falls, cognitive screening, depression screening, and overall physical activity. The incorporation of the STEADI algorithm and related tools can greatly enhance the opportunity to connect patients with community providers of EBPs.

3. **Developing Quality Measures for Chronic Conditions**

EBLC strongly supports this option on pages 22-23 of the paper. We would welcome the opportunity to continue to engage with the Working Group to provide additional details regarding the first three bullets, specifically:

- Patient and family engagement, including person-centered communications , care planning and patient-reported measures;
- Shared decision-making; and
- Care coordination, including care transitions, and shared accountability within a care team.

The National Council on Aging Center for Healthy Aging has analyzed many of the metrics developed for the management of chronic conditions and has concluded that the most thoughtful, reliable measures were developed by NCQA for Patient Centered Medical Homes (PCMH). Specifically, PCMH Standards 4 and 5 should be applied to the Physician Quality Reporting System (PQRS), Accountable Care Organizations (ACOs), Chronic Special Need Plans (SNPs), and Medicare Advantage Star Ratings. These measures capture critical elements of care that support self-management for people coping with chronic illness:

Standard 4: Plan and Manage Care

A. Identify Patients for Care Management
B. Care Planning and Self-Care Support
C. Medication Management
D. Use Electronic Prescribing
E. Support Self-Care and Shared Decision-Making

Standard 5: Track and Coordinate Care

A. Test Tracking and Follow-Up
B. Referral Tracking and Follow-Up
C. Coordinate Care Transitions

The intent of PCMH 4 is that plans systematically identify individual patients and manage and coordinate care based on need. The intent of PCMH 4 is to track and follow-up on all lab and imaging results, track and follow-up on all important referrals, and coordinate the care patients receive from specialty care, hospitals, other facilities and community organizations

In our view, for beneficiaries with multiple chronic conditions, most important among these are 4B and 4E:

PCMH 4B: Care Planning and Self-Care Support

Care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in 4A.

1. Incorporates patient preferences and functional/ lifestyle goals.
2. Identifies treatment goals.

3. Assesses and addresses potential barriers to meeting goals.
4. Includes a self-management plan.
5. Is provided in writing to patient/family/caregiver.

PCMH 4E: Support Self-Care and Shared Decision-Making
The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:

1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.
2. Provides educational materials and resources to patients.
3. Provides self-management tools to record self-care results.
4. Adopts shared decision-making aids.
5. Offers or refers patients to structured health education programs, such as group classes and support.
6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.
7. Assesses usefulness of identified community resources.

We also support the development of new measures that would focus on the percentage of patients who engage in evidence-based self-management programs, and measures that would improve health confidence, such as the Wasson Health Confidence Measure.[15]

4. **Expanding the Independence at Home Model of Care**

EBLC supports the option on pages 6-7 to expand the IAH demonstration. We are pleased that the demonstration's initial results have been quite positive. It is an excellent model for complex, frail patients who have difficulty leaving their homes even with transportation support. We have two suggestions for modifying the program: (1) improve incentives for integration with community-based agencies to improve patient health and well-being beyond the current medical model; and (2) before taking this nation-wide, review the current targeting strategy to ensure scalability.

5. **Maintaining ACO Flexibility to Provide Supplemental Services**

EBLC believes this option provides an important opportunity to address the access to evidence-based prevention and wellness programs through the connection to primary care screening and referral. ACOs should have a population-based strategy for patient engagement which is evidence-based that improves health confidence and self-management capacity. In general, we suggest clarifying that ACOs participating in the MSSP be able to furnish evidence-based prevention and wellness programs, transportation and other social services, including programs for chronic disease self-management, falls prevention, diabetes management, pain management, and caregiver support.

EBLC also supports the options on pages 28 and 29 of the paper to increase transparency at CMMI and conduct a study on Medication synchronization.

Thank you again for this opportunity to share our views. If you have any questions or if we can be of any further assistance, please contact me at ssnyder@picf.org.

Sincerely,

[15] See https://www.hcfama.org/sites/default/files/health_confidence_policy_brief_final.pdf

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